Social functioning and quality of life of people with mental disorders - questionnaire surveys

(Funkcjonowanie społeczne i jakość życia ludzi z zaburzeniami psychicznymi - badania ankietowe)

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Abstract – Introduction. Mentally ill people, due to stigmatisation in society, have significant problems in both professional and private spheres, mainly due to the reduction of interpersonal contacts. As a result, their quality of life is generally lower than that of mentally ill people.

The aim of the study. The aim of this work was to assess the quality of life and social functioning of people with mental disorders.

Materials and methods. In the study 56 men 44 women took part. The scale of social functioning of Max Birchwood was used for the assessment of demographic background and social functioning of the studied people, while the WHOQOL-BREF questionnaire was used for the assessment of quality of life.

Results. The general level of social functioning of most of the examined mental patients was abnormal. The examined patients were best evaluated in the category of possible independence, i.e. in terms of their real assessment of their own ability to cope in everyday life. Also their potential possibility of taking up employment was highly evaluated. The weakest respondents coped with their free time. The quality of their lives was most often assessed at an average level, and most of them were also not satisfied with their current state of health. The respondents functioned better from an environmental and social point of view than from a psychological and somatic one. Women were better able to evaluate their own quality of life and health, and age was not a factor determining this evaluation. Better educated people functioned better in the environmental field. The assessment of the quality of life of the respondents was reflected in the evaluation of their social functioning.

Conclusions. The general level of social functioning of the examined patients is low. The functioning on the level of the norm, accepted for healthy people, is presented by one in ten respondents on average. Among the assessed categories of social functioning of the examined patients, the highest was evaluated in the categories of possible independence and leaving the isolation. The lowest rating was given to them in the categories of recreation and entertainment and realized independence. The surveyed patients are most often not able to clearly assess the quality of their life, more often considering it worse than better and at the same time the majority are not satisfied with the current state of their health. Among the assessed categories of social functioning of the examined patients, the highest was in the categories of possible independence and coming out of isolation, the lowest in the categories of recreation and entertainment and realized independence. The quality of life of the examined patients was rated highest in the environmental field, although the scores obtained in this category were below half of the maximum number of points to be scored. Gender and education levels have a significant impact on quality of life. Women had a higher quality of life in social terms than men (p=0.020), and better educated people achieved a higher quality of life in the environmental domain (p=0.002). The better the general level of social functioning of the examined patients, the better their quality of life.

Key words - mental health disorders, scale of social functioning of Max Birchwood, quality of life assessment - WHOQOL-BREF questionnaire.

Streszczenie – Wstęp. Osoby chore psychicznie, ze względu na stygmatyzacje w społeczeństwie, mają znaczne problemy w sferze zawodowej jak i prywatnej, głównie ze względu na ograniczenie kontaktów międzyludzkich. W związku z tym jakość ich życia jest z reguły niższa w porównaniu do osób zdrowych psychicznie.

Cel pracy. Celem pracy była ocena jakości życia i funkcjonowania społecznego osób z zaburzeniami psychicznymi.

Materiał i metody. W badaniu wzięło udział 56 mężczyzn 44 kobiety. Do oceny podłoża demograficznego i funkcjonowania społecznego badanych wykorzystano skalę funkcjonowania społecznego Maxa Birchwooda, natomiast do oceny jakości życia, kwestionariusz WHOQOL-BREF.

Wyniki. Ogólny poziom funkcjonowania społecznego większości badanych pacjentów chorujących psychiczne odbiegał od normy. Badani pacjenci najlepiej ocenieni zostali w kategorii samodzielności możliwej, czyli w zakresie ich realnej oceny własnych możliwości radzenia sobie w codziennym życiu. Wysoko także oceniono ich potencjalną możliwość podjęcia pracy. Najsłabiej badani radzili sobie z czasem wolnym. Jakość swojego życia badani najczęściej oceniali na poziomie przeciętnym, w większości także nie byli zadowoleni z aktualnego stanu swojego zdrowia. Badani lepiej funkcjonowali pod względem środowiskowym i socjalnym aniżeli psychologicznym i somatycznym. Własną jakość życia i zdrowia lepiej oceniały kobiety, zaś wiek nie był czynnikiem

warunkującym tę ocenę. Osoby lepiej wykształcone lepiej funkcjonowały w dziedzinie środowiskowej. Ocena jakości życia badanych miała odzwierciedlenie w ocenie ich funkcjonowania społecznego.
Wnioski. Ogólny poziom funkcjonowania społecznego badanych pacjentów jest niski. Funkcjonowanie na poziomie normy, przyjętej dla osób zdrowych prezentuje średnio jeden na dziesięciu badanych. Spośród ocenianych kategorii funkcjonowania społecznego badanych pacjentów najwyżej oceniono w kategoriach samodzielności możliwej oraz wychodzenia z izolacji. Najniżej oceniono ich w kategoriach rekreacji i rozrywki oraz samodzielności realizowanej. Badani pacjenci najczęściej nie są w stanie jednoznacznie ocenić jakości swojego życia, częściej uważając ją za gorszą aniżeli za lepszą i jednocześnie większość nie jest zadowolona z aktualnego stanu swojego zdrowia. Spośród ocenianych kategorii funkcjonowania społecznego badanych pacjentów najwyżej oceniono w kategoriach samodzielności możliwej oraz wychodzenia z izolacji, najniżej w kategoriach rekreacji i rozrywki oraz samodzielności realizowanej. Jakość życia badanych pacjentów najwyżej oceniono w dziedzinie środowiskowej, choć uzyskane w tej kategorii oceny, mieściły się poniżej połowy maksymalnej liczby punktów do zdobycia. Istotny wpływ na jakość życia mają płeć i poziom wykształcenia. Kobiety cechowały się wyższą jakością życia pod względem socjalnym w porównaniu do mężczyzn (p=0,020), a osoby lepiej wykształcone osiągały wyższą jakością życia w domenie środowiskowej (p=0,002). Im lepszy jest ogólny poziom funkcjonowania społecznego badanych pacjentów tym lepsza jest jakość ich życia.

Słowa kluczowe – zaburzenia zdrowia psychicznego, skala funkcjonowania społecznego Maxa Birchwooda, ocena jakości życia - kwestionariusz WHOQOL-BREF**.**

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B. Gathering and listing data
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I. INTRODUCTION

The issue of how people with mental disorders function in society is very topical today. The increasingly frequent increase in the incidence of mental disorders in the human population - as a negative result of civilisation - triggers alarm and numerous questions. The historical features of similar phenomena from the past do not inspire optimism, as certain social prejudices have survived to our times. Famous scientific authorities place particular emphasis on studying the scale of the phenomenon. The introduction of a wide range of psychotropic drugs into the treatment of mental disorders has given patients the opportunity to be treated in mental health clinics, as well as in daily psychiatric wards. This innovation has significantly improved their quality of life. The lack of isolation has enabled patients (despite their ailments) to function more or less actively in society and continue to fulfil their social roles. [1-4] The current state of the problem prompted the authors to undertake their own research.

The aim of the study was to assess social functioning and quality of life in people with mental disorders.

II. MATERIALS AND METHODS

Material

The study involved 100 psychiatric patients. The examinations were carried out in day psychiatric wards (the Specialist Psychiatric Ward of the Prof. Antoni Kępiński Specialist Health Care Team in Jarosław; the Day Psychiatric Ward in the Anima Psychiatry Centre in Rzeszów and the Clinical Day Psychiatric Ward of the Fryderyk Chopin Regional Hospital No. 1 in Rzeszów). The research was conducted in the period from 1 January 2019 to 30 April 2019.

Table 1Characteristics of the test group

Factor under investigation	Factor categorisation	Number	%
Gender	women	44	44,0%
	Men	56	56,0%
Age	19-30 years	17	17,0%
	31-40 years	25	25,0%
	41-50 years	25	25,0%
	51-60 years	24	24,0%
	61-72 years	9	9,0%
Education	basic	8	8,0%
	core professional	31	31,0%
	average	44	44,0%
	higher	17	17,0%

Methods

The study used a tool consisting of two standardised questionnaires:

- The scale of Social Functioning - Max Birchwood,
- WHOQOL-BREF Quality of Life Questionnaire.

The Scale of Social Functioning (SFS) by Max Birchwood, which was adopted to Polish conditions by Maria Załuska. This scale allows to assess the functioning of mentally ill people in selected areas, examined according to the following categories, i.e:

- coming out of isolation,
- communication and interpersonal ties,
- social contacts,
- recreation and entertainment,
- independence implemented,
- independence is possible,
- professional activity.

Each of the SFS sub-scales consists of several dozen questions, scored on a scale from 0 to 3. This score, the so-called raw score, is then transformed, according to a key, into the total score of the subscale, ranging from 55 to 145 points. The subscale can be treated separately, but the individual results of the subscale can also be summed up, giving an overall assessment of the social functioning of the respondents. Each time, higher results indicate better functioning [5]. As a standard, adopted as a result of healthy people is considered a range of assessments ranging from 114 to 145 points, and the results below 114 points indicate the occurrence of dysfunctions in individual areas [6].

Standardised Quality of Life Questionnaire WHOQOL-BREF

The questionnaire consisted of 26 scoring questions on a scale from 1 to 5 points. The WHOQOL-BREF questionnaire provided information concerning the respondents' assessment of their own quality of life and satisfaction with their current health condition. The quality of life of the examined patients was also presented in four categories: somatic, psychological, social and environmental. In each of the mentioned categories of the WHOQOL-BREF questionnaire the results were scored on a scale from 0 to 100 points, and a higher number of points meant better quality of life [7].

Statistical methods

The data collected in the study were analysed statistically using Statistica 13.1 from StatSoft. Two types of data were analysed: qualitative and quantitative data. The qualitative data were presented in the form of numerical and percentage values, while the numerical data were presented in the form of mean, median, minimum and maximum values, first and third quartile and standard deviation. The differences between the results obtained in the two groups were assessed using Mann-Whitney's U test. Relationships between two variables of quantitative type were assessed using Spearman's rank correlation test. The level of statistical significance was assumed to be $p<0.05$.

III. RESULTS

Social functioning of the examined patients

The social functioning of the examined patients was assessed using the Max Birchwood Social Functioning Scale (SFS). The general functioning of the examined patients was considered as well as in seven categories of the questionnaire.

The overall functioning of the examined patients was assessed at the average level of 100.9 points. ± The results obtained by patients ranged from 66.1 to 134.9 points. Half of the patients received a score not exceeding 100.8 points.

The examined patients were best evaluated in the category of possible independence, i.e. in terms of their real assessment of their own ability to cope with everyday life. In this scale, the respondents received an average of

105.7 points. Next, slightly lower marks were given to the respondents in terms of leaving isolation - that is, their tendency to engage in social life (104.9 points). In the category of communication and interpersonal bonds, the respondents received an average of 104.6 points. Professional activity, i.e. the potential possibility of taking up employment by the respondents was rated at the average level of 103.4 points. In the category of social contacts, which assessed the ability to establish contacts in the most important social groups, such as family, friends and acquaintances, the respondents received an average of 100.7 points. The respondents were assessed poorly in the category of realized independence, i.e. their ability and activity in the scope of satisfying basic life needs - 94.6 points, and the weakest in the category of leisure activities - recreation and entertainment - 92.7 points. (Table 2).

Table 2.3Evaluation of social functioning of the respondents on the basis of the SFS questionnaire - summary results presentation

SFS [55-145 points]	DESCRIPTIVE STATISTICS							
	Number	M	Me	Min.	Max.	Q1	Q3	SD
Leaving the insulation	100	104,9	104,5	80,0	133,0	96,5	110,0	11,4
Communication and interpersonal relations	100	104,6	100,0	55,0	145,0	96,0	111,0	17,8
Social contacts	100	100,7	98,0	65,0	145,0	91,0	109,3	16,0
Recreation and entertainment	100	92,7	91,0	57,0	145,0	80,8	101,0	17,0
Self-reliance implemented	100	94,6	92,0	55,0	131,0	80,0	106,5	15,7
Independence possible	100	105,7	107,0	64,0	123,0	96,0	117,5	13,1
Activity at work	100	103,4	100,3	81,5	122,5	95,0	122,5	14,6
General functioning	100	100,9	100,8	66,1	134,9	93,0	108,3	11,2

The results of the SFS scale obtained by the examined patients were compared to the standards adopted for healthy people. In terms of general functioning, the results in the standard were obtained by 13.0% of patients, while the results of the remaining 87.0% of respondents were below the standard.

In the category of leaving the isolation, the results in the standard were obtained by 23.0% of the respondents, communication and interpersonal bonds were not impaired in the case of 16.0% of the respondents, social contacts in the standard were assessed in 20.0%, the ability to spend free time, assessed in the category of recreation and entertainment, in the limit of the standard were in 9.0% of the respondents, autonomy realized in the standard was in 13.0% of the respondents, and autonomy possible in 34.0% of the respondents, while capable of undertaking professional activity according to the adopted criteria of the standard was 31.0% of the respondents. The remaining majority of the examined persons, who were not mentioned, obtained results below the standard (Table 3).

Table 4.5Evaluation of social functioning of respondents on the basis of the SFS questionnaire - presentation of the results in relation to standards adopted for healthy people

SFS	Number of points	Number of patients	%
Leaving the insulation	<114	77	77,0%
	>114	23	23,0%
Communication and interpersonal relations	<114	84	84,0%
	>114	16	16,0%
Social contacts	<114	80	80,0%
	>114	20	20,0%
Recreation and entertainment	<114	91	91,0%
	>114	9	9,0%
Self-reliance implemented	<114	87	87,0%
	>114	13	13,0%
Independence possible	<114	66	66,0%
	>114	34	34,0%
Activity at work	<114	69	69,0%
	>114	31	31,0%
General functioning	<114	87	87,0%
	>114	13	13,0%

The level of social functioning of the examined patients in relation to standards is, depending on the analysed category, disturbed in 66.0 to 91.0% of the examined patients. The highest number (90.0%) of respondents presents disturbances in the scope of *Recreation and Entertainment*, at the same time attention is drawn by frequent disturbance of *Communication and interpersonal bonds* (these disturbances concerned 84.0% of respondents) or *Social Contacts* (registered in 80.0% of respondents) and *General Functioning* Disorder (these disturbances concerned 87.0% of respondents).

Quality of life of patients - study using the WHOQOL-BREF questionnaire

Quality of life of respondents - characteristics of domains

The quality of life of the examined persons was assessed using the WHOQOL-BREF questionnaire, showing it in four domains, i.e. the somatic, psychological, social and environmental domain. The quality of life of the examined persons was assessed the best in the environmental domain (49.58 pts.) successively in the social (41.7 pts.) and psychological (40.39 pts.) domain. The quality of life of the examined persons was assessed the least in the somatic field (39.53 points) (Table 4).

Table 6.7Quality of life assessment based on the WHOQOL-BREF questionnaire

WHOQOL-BREF [0-100 POINTS]	Descriptive statistics							
	Number	M	Me	Min.	Max.	Q1	Q3	SD
The somatic domain	100	39,53	38,00	0,00	100,00	25,00	6,00	21,53
The psychological domain	100	40,39	44,00	0,00	100,00	25,00	56,00	22,39
The social domain	100	41,70	44,00	0,00	100,00	25,00	53,00	23,14
The environmental domain	100	49,58	50,00	13,00	100,00	38,00	63,00	19,43

Quality of life of respondents in relation to gender

The quality of life of the examined women and men differed statistically significantly only in the social domain (p=0.020). Women were better evaluated in this respect in comparison with men (respectively at the average level of 47.16 points and 37.41 points for the groups mentioned above). There were no statistically significant differences in the quality of life of women and men in the somatic, psychological and environmental domains.

Table 8. 9Quality of life assessment based on the WHOQOL-BREF questionnaire in relation to the sex of the respondents

WHOQOL-BREF [0-100 points]	Women		Men		Z	p
	M	SD	M	SD		
The somatic domain	41,66	21,30	37,86	21,76	1,08	0,278
The psychological domain	43,45	23,51	37,98	21,37	1,32	0,188
The social domain	47,16	25,76	37,41	20,07	**2,33**	**0,020**
The environmental domain	53,98	20,72	46,13	17,78	1,87	0,061

Quality of life of subjects in relation to age

The presence of a statistically significant relationship between the quality of life of the examined persons and their age was not confirmed (p>0.05) (Table 6).

Table 10.11Quality of life assessment based on the WHOQOL-BREF questionnaire according to the age of respondents

Variables	R	p
The somatic domain and age	-0,11	0,293
The psychological domain and age	0,04	0,659
The social domain and age	0,15	0,133
The environmental domain and age	-0,06	0,571

Quality of life of respondents in relation to education

The presence of a statistically significant relationship between the quality of life of the environmental domain tested and the level of their education was confirmed (p=0.002). The better educated they were studied, the better was the quality of their life in the environmental domain. The correlation was moderate (R=0.31). The remaining correlations were statistically insignificant (p>0.05) (Table 7).

Table 12.13Quality of life assessment based on WHOQOL-BREF questionnaire according to education level

Variables	R	p
The somatic domain and education	0,14	0,152
The psychological domain and education	0,13	0,214
The social domain and education	0,08	0,452
The environmental domain and education	**0,31**	**0,002**

The presence of statistically significant correlations between the general level of social functioning of the examined patients and the assessment of their quality of life in each of the four domains: somatic, psychological, social and environmental (p<0.001) was demonstrated. All correlations were positive and were relatively strong. It was shown that the better the overall social functioning of the examined patients was assessed, the better the quality of their life in each of the domains (Table 8).

Table 14.15Quality of life assessment based on the WHOQOL-BREF questionnaire according to the general level of social functioning

Variables	R	p
The somatic domain and general social functioning	**0,60**	**<0,001**
The psychological domain and general social functioning	**0,58**	**<0,001**
The social domain and general social functioning	**0,59**	**<0,001**
The environmental domain and general social functioning	**0,61**	**<0,001**

IV. DISCUSSION

Mental illnesses have a very large impact on a patient's life. Despite the introduction of psychotropic drugs, which enable most patients to function on a daily basis, such people are still stigmatised in society. For this reason, such people often fall into isolation. This situation causes people with mental illness to have problems at every level of life, both professional and private. All this has a negative impact on their quality of life. [8]

On the basis of own research, it was found that the general level of social functioning in 87.0% of the mentally ill patients was abnormal. The highest respondents assessed their own abilities in terms of independence, and the worst they did not manage to organize their free time.

The quality of their lives is usually below average, and their current state of health is even worse. It was also observed that the respondents functioned better in environmental and social terms than in psychological and somatic terms. It has been shown that the age of patients does not determine their quality of life, while gender and education level have a significant impact on the quality of life. Gender and education, on the other hand, influence the variables studied. According to our findings, the examined women had a higher quality of life in social terms than men (p=0.020), and better educated people achieved a higher quality of life in the community domain (p=0.002).

Some authors do not confirm the observations we have made. The age and professional activity of patients from the Sagayadevan study were the only demographic factors affecting their quality of life, namely younger patients and the unemployed had a lower quality of life [6].

Makara-Studzińska *et al.* determined the occurrence of anxiety and depression disorders in people with schizophrenia and assessed the impact of these disorders on their quality of life. The study involved 115 patients with schizophrenia, and the research tool was a proprietary questionnaire, the WHOQOL-BREF quality of life scale and the scale of anxiety and depression disorders (HADS). Based on the conducted research, it was found that 78.26% of patients suffered from anxiety disorders, most often they were mild (48.70%), less often moderate (25.22%) or severe (9.57%). In contrast, depressive disorders affected a smaller number of patients, although still significant - mild depressive disorders occurred in 33.43%, moderate in 13.04% and severe in 5.22% of patients. It was also observed that patients' quality of life was negatively correlated with both the severity of anxiety and depression disorders, and the strongest correlations were observed in the psychological quality of life domain. The authors of the study concluded that the severity of anxiety and depression disorders in patients with schizophrenia is a strong predictor of their quality of life. [7]

The study carried out by Deenik *et al. aimed to* determine the relationship between physical activity and the quality of life of mentally ill patients. The study involved 184 patients and the research tools were ActiGraph GTX+ accelerometer, EuroQoL-5D and WHOQOL-BREF quality of life questionnaires, as well as the Psychical Activity Enjoyment Scale questionnaire. On the basis of the conducted research it was found that undertaking physical activity was positively correlated with all quality of life domains, except for the environmental domain. It was also observed that the greatest difference between the quality of life occurs between patients who do not undertake any physical activity and patients who undertake little physical activity [8].

The literature cited shows that patients should be encouraged to engage in physical activity, as even a small change can significantly improve their quality of life.

Foryś Z. *et al.* [9] defined the social functioning of patients of the daily rehabilitation unit with schizophrenia. Fifteen men and 15 women took part in the study, and the research tool was Max Birchwood's Social Functioning Scale. On the basis of the conducted research, significant disturbances in social functioning of the study participants were demonstrated in each of the 7 studied areas. Limitations in the social functioning of the participants of Foryś et al. were comparable to those of the participants of the own study. The participants of both studies did not function properly in the following areas: leaving isolation (66.6% vs. 77.0%), communication and interpersonal bonds (76.6% vs. 84.0%), social contacts (66.6% vs. 80.0%), recreation and entertainment (73.3% vs. 91.1%), autonomy realized (44.4% vs. 87.0%), possible autonomy (30.0% vs. 66.0%) and professional activity (76.6% vs. 69.0%).

On the basis of the obtained results of our own research we can observe that the participants of the study are characterized by worse social functioning in comparison to the participants of Foryś *et al.* in terms of each of the studied areas, except for professional activity [9].

When interpreting the results of the study, it should be remembered that the patients we examined suffered from various mental illnesses, while the participants in the Foryś study only suffered from schizophrenia. The authors of the

study point to a strong need for professional activation of people with chronic mental illness, due to significant difficulties in this area, especially young people. We fully share this view.

Podogrodzka-Niell and Tyszkowska point out that difficulties in engaging in social life by mentally ill people can be caused by significant stigmatisation of such people in society. Unfortunately, many people have a negative attitude towards mentally ill people, see them as a danger and try to distance themselves as far as possible. The stigmatisation of mentally ill people is also reflected in the labour market. Mentally ill people are employed less willingly and their salary is often lower than that of a healthy person. The studies mentioned above assume that professional activity is the most important factor in the 'social health' of the mentally ill. Taking up employment makes these people less isolated from the society, and the work itself can be a source of satisfaction and remuneration, ensuring financial independence [10].

Holubova *et al.* have determined the impact of demographic factors on the quality of life and the tendency for patients with depressive disorders and schizophrenia to stigmatise themselves. The study involved 103 schizophrenic patients and 80 depressed patients and used the Quality of Life Satisfaction and Enjoyment questionnaire, the Internalized Stigma of Mental Illness scale and a questionnaire on the demographic background of patients as a research tool. On the basis of the conducted research, it was established that the quality of life was similar in both groups of patients, however, patients with schizophrenia were more prone to self-stigmatisation. Moreover, it has been shown that professional activity had a significant impact on the quality of life of the patients - both patients with schizophrenia and patients with depression who were professionally active were characterized by a higher quality of life [11].

The study carried out by Unsar *et al. aimed to* identify factors affecting quality of life, the severity of depressive disorders, daily and social life in older people. The study involved 912 people over 60 years of age, and the research tool was the Katz scale, the scale of perceived social support, the geriatric scale of depression and the EQ-5D quality of life scale. The study found that quality of life was higher and depressive symptoms were lower in younger people, taking less drugs, less frequently hospitalized and with more offspring. In addition, people who were more active in everyday and social life had a higher quality of life and less depressive disorders. The authors of the study draw attention to the need for early diagnosis of chronic diseases and depression using reliable scales, as well as the development of effective strategies to deal with the problems of older age, in order to increase their quality of life [12].

Due to the nature of mental illness, sick people are exposed to stressful situations on a daily basis, especially when dealing with other people. Social campaigns should be conducted to reduce the stigmatisation of mentally ill people, which will allow them to become more involved in society and have a positive impact on their quality of life.

V. CONCLUSIONS

1. The general level of social functioning of the examined patients is low. The functioning at the level of the standard adopted for healthy people is presented on average by one in ten respondents.
2. Among the assessed categories of social functioning of the examined patients, the highest scores were given in the categories of possible independence and leaving the isolation. The lowest was evaluated in the categories of recreation and entertainment and realized independence.
3. The examined patients are most often not able to clearly assess the quality of their
4. The majority is not satisfied with their current state of health.
5. The quality of life of the patients surveyed was rated highest in the environmental field, although the scores obtained in this category were below half of the maximum number of points to be scored.
6. Gender and education levels have a significant impact on quality of life. Women had a higher quality of life in social terms than men (p=0.020), and better educated people achieved a higher quality of life in the community domain (p=0.002).
7. The better the overall level of social functioning of the patients examined, the better their quality of life.

VI. REFERENCES

[1] Vaillant GE. Positive mental health: Is there a cross-cultural definition? World Psychia 2012; 11: 93–99.
[2] Lingiardi V, McWilliams N. The Psychodynamic Diagnostic Manual – 2nd edition (PDM-2). World Psychia 2015; 14: 237–239.
[3] Gallagher S, Varga S. Social cognition and psychopathology: a critical overview. World Psychia 2015; 14: 5–14.

[4] Gałecki P, Szulc A. Psychiatria. Wrocław; Edra Urban & Partner, 2018.
[5] The World Health Organization Quality Of Life (WHOQOL) – BREF – Skrócona wersja ankiety oceniającej jakość życia, World Health Organisation 2004.
[6] Sagayadevan V, Lee SP, Ong C *et al.* Quality of Life across Mental Disorders in Psychiatric Outpatients. Ann Acad Med Singapore 2018; 47(7): 243–252.
[7] Makara-Studzińska M, Wołyniak M, Kryś, K. Influence of Anxiety and Depression on Quality of Life of People with Schizophrenia in the Eastern Region of Poland. ISRN Psychiatry 2012: 1: 1–6.
[8] Deenik J. Physical activity and quality of life in long-term hospitalized patients with severe mental illness: A cross-sectional study. BMC Psychiatry 2017; 17(1): 1–11.
[9] Foryś Z, Cepuch G, Dębska G, Franczak M. Funkcjonowanie społeczne pacjentów dziennego oddziału rehabilitacyjnego chorych na schizofrenię. Zdr Publ 2013; 3: 17−22.
[10] Podogrodzka-Niell M, Tyszkowska M. Stygmatyzacja na drodze zdrowienia w chorobach psychicznych – czynniki związane z funkcjonowaniem społecznym, Psychiatr Pol 2014; 48(6):1201–1211.
[11] Holubova M. Comparison of self-stigma and quality of life in patients with depressive disorders and schizophrenia spectrum disorders - A cross-sectional study. Neuropsychiatr Dis Treat 2016; 12: 3021–3030.
[12] Unsar S, Dindar I, Kurt S. Activities of daily living, quality of life, social support and depression levels of elderly individuals in Turkish society. J Pak Med Assoc 2015; 65(6): 642–646.